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About this *thing* we call mental health literacy

Acerca dessa coisa a que chamamos literacia em saúde mental
Sobre esa cosa que llamamos alfabetización en salud mental

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Abstract
Background: Mental health literacy is a key concept in the field of mental health promotion and prevention. However, an expansion of the concept has been proposed that may distort its scope.
Objective: To critically explore the concept of mental health literacy and its evolution, starting from its origin and subsequent developments, and considering its potential and challenges.
Main topics under analysis: Mental health literacy; positive mental health; mental health prevention and mental health promotion as principles anchoring the origin and development of the concept.
Conclusion: The promotion of mental health as part of the concept of mental health literacy is a positive step as it provides a perspective based on salutogenesis. The addition of the adjective positive to the original term serves the ideological commitments and agendas of some fields of knowledge more than the actual promotion of mental health. Furthermore, mental health literacy interventions aim to reduce the stigma associated with mental illness and people with mental health conditions and increase help seeking.

Keywords: mental health literacy; mental health; health promotion; disease prevention

Resumo
Enquadramento: A literacia em saúde mental é um conceito-chave no panorama da promoção e prevenção em saúde mental, contudo tem sido proposto uma expansão do conceito que pode desvirtuar o seu raio de ação.
Objetivo: Analisar criticamente o conceito de literacia em saúde mental e sua evolução, a partir da sua génese e desenvolvimentos ulteriores, perspetivando potencialidades e desafios.
Principais tópicos em análise: Literacia em saúde mental; saúde mental positiva; saúde mental preventiva e promoção da saúde mental enquanto tradições onde ancora a génese e desenvolvimento do conceito.
Conclusão: É positivo valorizar a promoção da saúde mental no conceito de literacia em saúde mental, imprimindo-lhe um cunho assente na perspetiva da salutogénese. Contudo, a adição do adjetivo *positiva* no termo inicial serve mais os compromissos e intentos ideológicos de algumas áreas do saber que propriamente a promoção da saúde mental. A redução do estigma associado às doenças e doentes mentais e o aumento da procura de ajuda, são objetivos de ação das intervenções ao nível da literacia em saúde mental.

Palavras-chave: literacia em saúde mental; saúde mental; promoção da saúde; prevenção das doenças

Resumen
Marco contextual: La alfabetización en salud mental es un concepto clave en el panorama de la promoción y la prevención de la salud mental. Sin embargo, se ha propuesto ampliar el concepto de una manera que puede distorsionar su ámbito de actuación.
Objetivo: Analizar críticamente el concepto de alfabetización en salud mental y su evolución, partiendo de su origen y desarrollos posteriores, examinando su potencial y sus retos.
Principales termas en análisis: Alfabetización en salud mental; salud mental positiva; salud mental preventiva y promoción de la salud mental como tradiciones que anclan el origen y el desarrollo del concepto.
Conclusión: Es positivo destacar la promoción de la salud mental en el concepto de alfabetización en salud mental, dándole un carácter basado en la perspectiva de la salutogénesis. Sin embargo, la adición del adjetivo *positivo* al término inicial sirve más a los compromisos ideológicos y a las intenciones de algunas áreas de conocimiento que a la promoción real de la salud mental. Reducir el estigma asociado a las enfermedades mentales y a los pacientes, y aumentar la búsqueda de ayuda son los objetivos de las intervenciones de alfabetización en salud mental.

Palabras clave: alfabetización en salud mental; salud mental; promoción de la salud; prevención de enfermedades

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Introduction

Coined by Jorm and colleagues in the late 1990s (Jorm et al., 1997), mental health literacy (MHL) is considered a critical determinant of health (World Health Organization [WHO], 2022) and a key concept for anyone who wants to engage in mental health promotion (MHP) and mental illness prevention (MIP) (Loureiro et al., 2012). In the Portuguese context, the 2019 Report of the Portuguese National Health Commission not only mapped the problems and challenges facing mental health (MH) in Portugal but also recommended, among other things,

> the creation of a national strategy for MHP among the Portuguese population, focusing specifically on MHL in different contexts and as part of an integrated, intersectoral, participatory, comprehensive, and lifecycle national strategy for health promotion (Conselho Nacional de Saúde, 2019, p. 97).

The increasing relevance that the concept of MHL has acquired over the last 25 years (Jorm, 2020) has been characterized, especially in the last decade, by the emergence of proposals to redefine the concept (Kusan, 2013; Kutcher et al., 2016). On the one hand, these proposals are based on the need to bring MHL closer to its counterpart, health literacy (HL), as MHL emerged within the conceptual framework of HL and therefore needs to be understood within it. On the other hand, there is a movement to expand the concept of MHL, suggesting that it should include other constructs such as positive mental health (PMH), stigma, and help-seeking efficacy (Kutcher et al., 2016).

From the point of view of the authors calling for this change (Bjørnsen et al., 2017; Kusan, 2013; Kutcher et al., 2016), the definition proposed by Jorm et al. (1997) is tied to the biomedical model and places emphasis only on the prevention of mental illness (MI) and psychiatric conditions, making MH synonymous with the absence of illness.

The corollary of this *nouvelle vague* was the addition of the adjective "positive" to the term MHL, which led to the emergence of the concept of positive mental health literacy (PMHL) (Bjørnsen et al., 2017), as opposed to MHL, which is in line with the work of Jorm et al. (1997). The criticism also extended to how the concept of MHL has been assessed, specifically by the Survey of Mental Health Literacy in Young People - Interview Version - (Jorm et al., 1997), the instrument that underpins most of the evidence on MHL produced nationally (Loureiro, 2015) and internationally (Jorm, 2019). However, the new proposed instruments that have emerged do not assess MHL as intended. Instead, these instruments mostly assess literacy on MI, thus leaving unclear what they measure in reality (Aller et al., 2021).

Thus, MH researchers and educators who want to develop research or interventions in the field of MHL may make two types of mistakes related to or arising from the concept, specifically:

> 1st – failure to conduct interventions grounded in a coherent and appropriate theoretical and conceptual line: This may be due to a lack of definition of the concept of MHL that they adopt, or even to a lack of guiding theories for intervention. Sometimes, researchers commit a certain apostasy when they cut out theories, amputate important parts of the concepts, or forget the entire structure on which the MHL-promotion interventions should be based.
>
> 2nd – misunderstanding the conceptual definition of MHL: This may be because researchers and educators who advocate a PMH-centered and salutogenic perspective (these are two different concepts) of MHL may fall into the "pathogenesis trap" when they move from the conceptual phase of their studies to the methodological phase, especially when choosing data collection instruments.

The need to question the construction and redefinition of the concept and its components is the driving force behind this article, whose aim is to carry out a critical examination of the concept of MHL and its evolution, beginning with its origin (associated with HL) and subsequent developments and highlighting its potential, in order to envisage the challenges facing the study of MHL, with the possible inclusion of PMH in the concept.

Development

Doak et al. (1985) wrote the first handbook on literacy applied to health. However, the definition of HL and the conceptual work to operationalize it did not come until the early 1990s, when Nutbeam et al. (1993) defined it as an individual's ability to access, understand, and use health-related information to promote and maintain good health. Still, it was not until the end of that decade that research began to operationalize the concept more consistently and to develop policies to promote it (Loureiro et al., 2012).

At the same time, the concept of MHL was introduced by Jorm and colleagues (Jorm et al., 1997), which, as stated by the authors, emerged from the concept of HL. MHL is then defined as "knowledge and beliefs about mental disorders, which aid their recognition, management or prevention" (p. 182). They further elaborated and operationalized MHL into six components.

A careful reading of the conceptual definitions of HL (Nutbeam et al., 1993) and MHL (Jorm et al., 1997) reveals that the definitions seem to be based on two different perspectives or traditions of health education, as evidenced by their use of the terms "prevention" and "promotion".

While HL explicitly refers to the "promotion" of good health, in accordance with the guidelines emanating from the Ottawa Declaration, in which the biopsychosocial model and the concept of lifestyle and well-being in relation to health also emerged, Jorm et al. (1997) refer to the "prevention" of mental disorders. Although Jorm used the term prevention in conjunction with recognition and management, seemingly favoring the perspective of preventive MH, the definition of MHL does not exclude aspects of health promotion (HP). On the contrary, the

management of MH in everyday life implies awareness of its maintenance and improvement, in order to enhance the MH of individuals (Jorm, 2020). It is also true that both literacies, once established, have followed autonomous and independent paths.

The journey that HL has taken over the last 20 years is a long one, both in terms of the proliferation of explanatory models and the development of conceptual definitions (Sørensen et al., 2012). The literature contains at least 250 definitions of the concept of HL (Malloy-Weir et al., 2016). Although these concepts share many common aspects, this proliferation and diversity of definitions shows that the concept is flexible and adapts to very different and ever-changing socio-cultural and economic contexts. However, this proliferation and diversity can also be problematic for policymakers, health professionals, researchers, and even citizens.

Therefore, the generally accepted definition of HL states that

> Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course (Sørensen et al., 2012, p. 3).

Expansion of the concept of mental health literacy and proximity to health literacy

The production over time of definitions and models for the concept of MHL is not comparable in any way to that of HL. Although the first criticisms of the MHL concept appeared in 2013 (Bjørnsen et al., 2017; Kusan, 2013; Kutcher et al., 2016), only two "new" proposals for defining the concept have stood out (Kusan, 2013; Kutcher et al., 2016).

In 2012, Jorm adapted the concept presented in 1997 (Jorm et al., 1997). This adaptation of the MHL concept now includes the idea of MHP problems and another component related to MH first aid. Jorm (2012) also reaffirms the importance of MH knowledge as a basis for interventions aimed at the development of adequate levels of MHL, in other words, to associate it with MH interventions and consequently to the improvement of individual and collective MH (Jorm, 2012).

The components, in accordance with Jorm et al.'s earlier work (1997), are referred to as:

> (a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis (Jorm, 2012, p. 231).

As mentioned above, Kusan (2013) was the first to criticize the MHL concept developed by Jorm et al. (1997). For the author, Jorm's enunciation of mental disorders is a translation of the knowledge of the contents of the Diagnostic and Statistical Manual of Mental Disorders ([DSM] Kusan, 2013). For Kusan, MHL is more than the symptoms of psychopathology and "the self-generated and acquired knowledge with which people negotiate their MH" (2013, p. 14).

The series of criticisms that emerged later were echoed both in the expansion of the definition of MHL and its proximity or even alignment with HL (Kutcher et al., 2016), and in the development of new proposals for data collection instruments.

Kutcher et al. (2016) began by stating that the definition of MHL should be incorporated into the broader field of HL and serve as a support for MHP, as it is known that HL (and MHL) is not only a basis/foundation/support for MHP, but it can also be "an outcome, a partner, a driver, and an informant" (Gugglberger, 2019, p. 888).

In Kutcher et al.'s (2016) definition, MHL is defined as:

> (a) understanding how to obtain and maintain positive mental health; (b) understanding mental disorders and their treatments; (c) decreasing stigma related to mental disorders; (d) enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities) (Kutcher et al., 2016, p. 155).

Kutcher et al. (2016) also state that MHL includes three interrelated concepts, namely knowledge, attitudes, and help-seeking efficacy, which they consider are consistent with the concept of HL proposed by Sørensen et al. (2012) and currently in force.

At first glance, this proposal to expand the concept appears to be necessary, as it allows for the explicit inclusion of MH issues in MHL. Yet, at the same time, it brings together and incorporates different theories and concepts, which can become a Gordian knot as it involves different traditions and fields of knowledge with very different lines of intervention, knowledge, and skills.

The original definition of MHL (Jorm et al., 1997) and the new orientations proposed for the concept and its expansion form the basis of Spiker and Hammer's (2018) critical analysis of the MHL construct. For Spiker and Hammer (2018), MHL should be considered a theory, since as a construct it violates many of the principles that make up what is considered an acceptable construct definition.

However, from another perspective, we may consider that Jorm et al.'s (1997) construct definition is valid because it is a "good concept" with little room for conceptual refinement. In this case, the two-decade consensus around Jorm et al.'s definition is justified by the fact that the concept respects the "characteristics of familiarity, resonance (it is distinct and "echoes" differently from HL), parsimony, coherence, differentiation, depth, theoretical utility, and utility in the field of action in which it was developed" (Gerring, 1999, p. 367).

From the medicalization of mental health to good mental health

The "understanding [of] how to obtain and maintain positive mental health" in Kutcher et al.'s (2016) proposal,

rather than the inclusion of the components of stigma reduction and help-seeking efficacy, is, in our opinion, the component that most contributes to the debate on expanding the concept of MHL.

In recent decades, there has been much criticism of the medicalization of health and, consequently, of MH. This psychiatrization of everyday life translates, for example, into the belief that psychotropic drugs lead to MH, and is reflected in the search for and use of psychotropic drugs as a solution to all kinds of suffering and discomfort in everyday life, enabling individuals to endure life and cope with frustrations. More recently, the idea has been promoted that investing in positive health, thus promoting PMH, is sufficient to achieve good mental health (GMH), as suggested by the salutogenic movement (Bodryzlova & Moullec, 2023). In this case, the individualistic perspective of MH is overemphasized, reinforcing the role of individuals as the sole agents of their health status.

The question then arises: what is GMH or PMH?

The tendency is to oppose GMH to MI or poor or deficient MH.

From the outset, one fact is clear: most of the public and published evidence tends to speak of MH in terms of MI ("negative MH"), and therefore in terms of deficient or poor MH, as opposed to GMH. This is illustrated by the following example: the epidemiological studies carried out in Portugal under the generic name of "Mental Health in Numbers" are nothing more than the statistical distribution of "mental disorders" or those resulting from them, leaving nothing to be said about MH, which includes an immense anonymous mass of individuals who supposedly thrive in silence. In short, little is known about MH because investment is focused on MI.

In addition, there is no consensus on what constitutes GMH (Fusar-Poli et al., 2020), more specifically on what core areas should be achieved. However, some models put well-being at the center of interventions, as proposed by Keyes (2014). This author considers the enhancement of positive feelings and functioning as key factors in achieving and maintaining PMH (Galderisi et al., 2015). In this context, for Fusar-Poli et al. (2020), GMH can be understood as a state of well-being that allows individuals to be functional and productive and to cope with the normal stresses of their daily lives. It includes different domains, namely:

> (i) mental health literacy, (ii) attitude towards mental disorders, (iii) self-perceptions and values, (iv) cognitive skills, (v) academic/ occupational performance, (vi) emotions, (vii) behaviors, (viii) self-management strategies, (ix) social skills, (x) family and significant relationships (xi) physical health, (xii) sexual health, (xiii) meaning of life, (xiv) and quality of life (p. 34).

In addition to the inclusion of a large number of domains, GMH, which is a component of PMHL in the Kutcher et al. (2016) definition, is now viewed as a component of Fusar-Poli et al.'s (2020) concept of GMH. This arbitrary status of the variables does not clarify the concept and may hinder the development of explanatory models and the design of interventions.

We believe that the aim of including this component is to evaluate and view MHL through the prism of PMH. In this case, mental well-being is a key concept in PMH (Galderisi et al., 2015), thus the importance of salutogenesis as opposed to pathogenesis.

Therefore, we agree that MHL should aim to maximize the potential of individuals and promote their integrity so that they can thrive, in accordance with the WHO's definition of MH (2022) which states that:

> Mental health is an integral part of our general health and well-being (…). Having good mental health means we are better able to connect, function, cope and thrive. Mental health exists on a complex continuum, with experiences ranging from an optimal state of well-being to debilitating states of great suffering and emotional pain (WHO, 2022, p. 2).

As mentioned above, there are various proposals to include the MH component in the concept. One of the proposed solutions was to rehabilitate the concept of PMH based on two perspectives: one, based on the work of the Austrian psychologist Jahoda, who focused more on the eudaimonic aspects of well-being, and the other, in line with the work of Gurin et al. (1960), who focused more on the hedonic aspects of subjective well-being - subjective or emotional aspects of well-being, as confirmed by Keyes (2014).

In the first case, Jahoda understood PMH to include the attitudes that individuals have towards themselves (self-actualization, which leads individuals to explore their potential) and the domain of the environment, as well as their ability to adapt to situations (autonomy in the sense of identifying and solving problems). For the author, PMH encompasses six dimensions: attitude towards oneself; growth, development, and self-actualization; integration; autonomy; perception of reality; and mastery of the environment (Galderisi et al., 2015). This approach to positive health is influential, especially in association with the work of Lluch-Canut (2020), who defines four postulates of PMH: a) PMH is a dynamic and fluctuating construct; b) it includes positive and negative feelings, thoughts, and behaviors; c) it has limits that must be controlled; and d) the factors in the model are interrelated and there may be exchanges between them. Concerning postulate c), it should be noted that alert threshold states imply knowledge of the duration, the intensity, the frequency, the incapacity generated, the difference from the individual's usual response pattern, and the consequences of these states for the individual. At the level of postulate d), the factors of the model (called the Multifactorial Model of PMH) include personal satisfaction, pro-social attitude, self-control, autonomy, problem-solving and self-actualization. and interpersonal relationship skills.

Therefore, PMH is viewed globally as a dynamic and fluctuating state in which individuals try to feel and be as good as possible in the circumstances in which they find themselves. More specifically, it corresponds to

> a state in which individuals are able to maintain a certain level of personal satisfaction with them-

> selves and their lives, a certain capacity to accept others and different facts, and a certain degree of emotional self-control and autonomy, are able to solve problems as they arise while maintaining an attitude of growth and self-actualization, and are able to establish and maintain satisfactory interpersonal relationships (Lluch-Canut, 2020, p.4).

Considering the formulation presented by Lluch-Canut, those who want to act at the level of PMH should focus their interventions on aspects of MHP, particularly individual empowerment leading to the maintenance of PMH in its different components or factors, as well as on aspects related to MIP. We believe that the merit of Lluch-Canut's proposal lies in the fact that it promotes well-being, but also includes MIP, especially when it states that individuals must deal with and embrace states of malaise, in other words, PMH also includes "negative" states. Furthermore, the concept of alert thresholds now implies the concept of mental health problems referred to by Jorm (2012).

However, a broader field of studies related to the concept of well-being has been developing independently in psychology. This work emerged with the establishment and development of the psychology of well-being, since the 1980s, when the concept of well-being was linked to that of health and extended to the concept of MH.

This movement included two strands: Subjective well-being - a hedonic perspective that includes two dimensions: one cognitive (satisfaction with life) and the other emotional (positive and negative affections), or in other words, it concerns how individuals value themselves and their lives; and Psychological well-being - the eudaimonic perspective, which refers to individuals' ability to face the challenges in life in order to achieve full functioning and maximize their potential. These two strands are embodied in the WHO's definition of MH (2022), as PMH encompasses positive emotions and positive functioning, as well as the perspective of social well-being (Keyes, 2014).

Thus, PMH is considered from the perspective of emotional well-being (including feelings of happiness and life satisfaction), psychological well-being (including positive individual functioning leading to self-actualization), and social well-being, which corresponds to full social functioning and includes the individual's functioning in terms of social engagement, integration, acceptance, contribution, actualization, and coherence (Keyes, 2014).

The WHO Report (2022, p. 11) includes a recent operationalization of this proposal, in which MH includes four components that relate to individuals' abilities to a) relate (e.g. maintain positive relationships, contribute to the community), b) develop (e.g. apply cognitive skills, make healthy choices), c) respond to difficulties (e.g. manage stress, adapt to change), and d) thrive throughout the life cycle (e.g. develop new skills, feel good).

To prevent and/or to promote? Consensus and opposition

To respond to these concerns stemming from the concept of MH, the question arises: should the perspective of MHP or preventive MH, or both, be prioritized, or valued in interventions aimed at increasing MHL?

As mentioned above, if the rationale is based on, or has as its starting point, interventions in favor of citizens' MH (i.e., their MH and well-being), regardless of the stage of the life cycle they are in, it must be considered that MH knowledge is often limited to the incidence and prevalence of MI, with MH being studied from the perspective of MI.

Some models and concepts can help to frame both perspectives in terms of MHL. An example of this is the Dual Continuum Model by Keyes (2014), which can be used as a guide for framing MHL-promoting interventions while considering both MH and MI, as it incorporates both the MHP and MIP perspectives.

Keyes (2014) argues that there are two continuums (Figure 1), one for MH and the other for MI, which, although related, are distinct.

The MH continuum ranges from the individual who is not emotionally well and not functioning adequately (languishing) to the individual who enjoys an optimal state of emotional well-being and is functioning positively (flourishing). The MH continuum embodies the presence and absence of PMH (symptoms of mental well-being).

The MI continuum ranges from the presence of psychiatric symptoms (at one extreme) that interfere with the individual's functioning to the absence of these symptoms (at the other extreme). In short, the MI continuum indicates the presence and absence of symptoms.

Therefore, PMH is understood to include the presence of symptoms that imply positive functioning (psychological and social) and the presence of emotional well-being (positive emotions).

Regarding the concept of MH, Keyes (2005) defines it as a "syndrome of symptoms of hedonia and positive functioning, operationalized by measures of subjective well-being - individuals' perceptions and evaluations of their lives and the quality of their functioning in life" (p. 514).

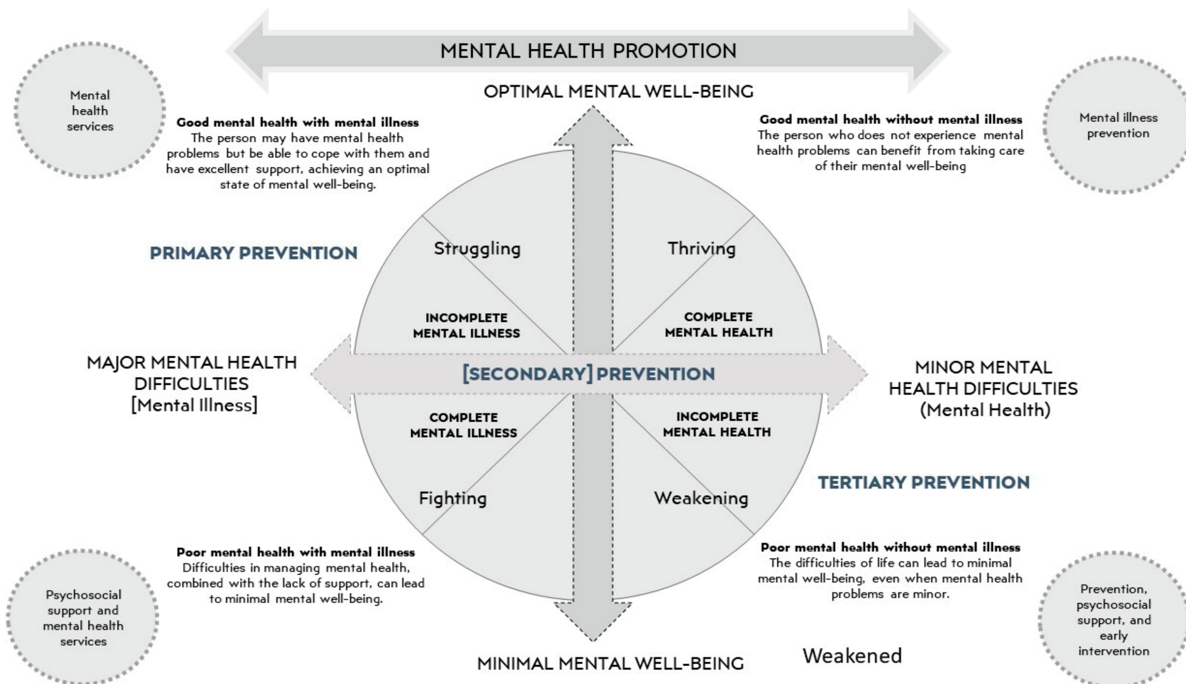
According to Keyes (2014), the model categorizes individuals according to their MI status and, at the same time, their MH status (languishing/moderate/flourishing), and makes it possible to speak of complete/incomplete MH and complete/incomplete MI. According to Keyes (2014), the first implication of the model is that the absence of MI does not imply the presence of MH, just as the presence of MI does not imply the absence of MH.

Figure 1 shows that it is possible to frame the aspects of prevention and promotion simultaneously with the promotion of PMH (Jay et al., 2017). In the case of prevention, continuous investment in well-being and MH is key to preventing the development of MI (Elmes et al., 2021; Everymind, 2017).

The model divides prevention into primary, secondary, and tertiary components. While primary prevention aims to prevent the onset of conditions that affect MH, secondary prevention aims to reduce the impact and outcome of MI. Tertiary prevention focuses on supporting recovery (Singh et al., 2022).

Figure 1

Dual continuum model MH - MI and framework of MHP and MIP



Source: adapted from Elmes, A., Dufour, R., Olekalns, A., & Clark, Kelly. (2021). *Mental health deep dive: Effective and promising practice in mental health promotion with young people.* Centre for Social Impact, University of New South Wales, Swinburne University of Technology, and University of Western Australia.

Regarding the suggestion to incorporate stigma reduction and improved help-seeking efficacy as components of MHL (Kutcher et al., 2016), we believe that this is more a consequence of the proximity to the concept of HL, as both stem from or are goals that result from MHL interventions.

Moreover, social stigma is a distinct and robust area of research with extensive theoretical construction and scientific evidence, whereas help-seeking efficacy is a behavioral approach.

Conclusion

The expansion of the concept of MHL by introducing the contributions of PMH as a component is probably the most important aspect in the expansion of the original concept of MHL, as it forces a rethinking of the logic of MHP. Putting a salutogenic perspective on intervention guidelines improves the management of MH and well-being in everyday life. However, we also believe that this is the component that raises the most questions and controversies in terms of health education since it involves the intersection of different theoretical and conceptual approaches and involves different fields and types of professional knowledge.

In our opinion, the adjective "positive" in the original name of the concept is unnecessary and does not add anything to MHL, except for changing its name to PMHL. The benefit to citizens in terms of promoting MHL comes fundamentally from including knowledge of MH as one of the components of MHL, regardless of the theoretical approach or conceptual perspective adopted, and not from renaming the term.

In addition, we think that reducing stigma and increasing self-help efficacy are both goals of MHL-promoting programs, and, contrary to what is often claimed, both goals are present in the pioneering work of Jorm and colleagues (Jorm et al., 1997).

It is also worth noting that much of the research conducted in the last decade under this PMH proposal has focused on MHL in relation to MI, meaning that the measurement instruments created and used do not reflect what is proposed in the renaming of the concept. These issues are exacerbated by an apparent lack of distinction between knowledge about health/MI, beliefs about MI, and even attitudes.

In our understanding, MHL includes beliefs, attitudes, and knowledge about MH and MI, as well as the skills that enable individuals, regardless of their health status, to act in everyday life, managing and mobilizing their personal and community resources to maintain their MH and that of those around them. It also includes knowledge about health services and health information and is part of the belief and value systems of the cultures to which individuals belong.

Therefore, investing in and caring for MH is imperative, and in this sense, MHL interventions, as a determinant of health, should involve providing tools, strategies, and resources that enable individuals to manage their MH and well-being on a daily basis. Furthermore, these interventions should be inseparable from economic and social policies, especially health policies. The time has come to see MH as an investment and to take action to improve people's MH.

Author contributions

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